RAI Panel Q&As for July, 2011

Chapter 1

Chapter 2

1. **EOT - QUESTION**: I am hearing many different explanations of this assessment and would appreciate it if you would clarify the meaning to me. I am from Minnesota and with our government shut down I am not able to discuss this with my RAI coordinator. We normally provide therapy Mon-Fri but if someone is in a skilled part A ARP they will come to see the residents on a Saturday or holiday. Over the 4th of July holiday which involved 3 consecutive days (Sat-Sun-Mon) our therapists refused to see our skilled part A residents unless they were in an ARP. They stated the missing 3 day rule is a proposal only and that they do not have to see them until this is made law. Is this correct or do we need to do an EOT on all skilled residents if they have missed 3 consecutive days in the 7 day week period?
   ANSWER: If your facility usually provides therapy on weekends and holidays, then you have to consider the weekend as usual therapy days and after the weekend was missed, Monday would be the third day missed only if your Therapy department would provide services on a Holiday. If the therapy is never provided on weekends and/or a holiday then no EOT OMRA assessment would be required. This is not a proposal and not something that the therapy department is at liberty to decide. This has been covered in the manual since the beginning of MDS 3.0 and in training provided by CMS. See websites below:
   http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp
   http://www.cms.gov/SNFPPS/Downloads/MDS30andRUGIV-audioconference11092010.pdf
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2. **SOT QUESTION:** A facility admitted a Medicare part A resident on 07/08/11 who was receiving Skilled nursing and Rehab however since the resident did not have a enough minutes it was calculated on the Nursing RUG. The facility now wants to start the Start of Therapy OMRA as of the 07/13/11 and they wanted to know what date they should pick up as the first day of therapy for the SOT OMRA? Are they supposed to start on 07/13/11 as the first day even though the resident was receiving the therapy services from the 07/08/11 however not enough minutes for rehab RUG, or can they go back and pick up the first day of the therapy for the SOT OMRA (07/08/11) even though the minutes still was not enough until 07/13/11?
   ANSWER: A SOT OMRA can only be completed 5 to 7 days after the start of therapy so it would depend on the day that therapy started. It doesn't matter if that date was in the look-back period for the previous MDS because that MDS did not generate a rehab RUG. When you do a SOT OMRA, it will pay the rehab RUG starting with the date that therapy started, so it does not matter if you use day 5, day 6 or day 7 after the start of therapy -- the resulting RUG will always be effective the day therapy actually started. However, you must always count from the day therapy actually started to determine the correct ARD for day 5, day 6 and/or day 7 -- and then determine which one of the three you want to use.
   In addition to the above, the following information was provided by CMS:
   The Start of Therapy OMRA is a new assessment type and it is optional. It is optional if you want to obtain a therapy RUG, which is a Rehabilitation Plus Extensive Services or a Rehabilitation only. You may complete this assessment any time during the stay. **However, it is not to be completed to increase or decrease a therapy RUG once the resident is assigned a therapy RUG**. It is only to obtain the therapy RUG where the resident is not already in a therapy RUG. The ARD must be set five to seven days after the start of first therapy day. As we've stated before, the first therapy day is the evaluation date. If the evaluation requires two days to be completed, it is the first day that you started the evaluation. Payment will begin on the first day of therapy, the earliest date. We do index maximize, keep that in mind when you're completing the Start of Therapy OMRA. You must be aware of your CMIs (Case Mix Indices) and accordingly determine whether or not you should complete the Start of Therapy OMRA. CMS strongly recommends that you do not combine this OMRA with the 5-day assessment with the exception being for the short stay assessment. When you combine the 5-day with the Start of Therapy OMRA, you must be billing the non-therapy HIPPS for the days prior to the earliest start of therapy date. And then you would bill the therapy HIPPS beginning the first day therapy started.
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3. **LOA - QUESTION**: It has been acceptable in the past to treat multiple nights out, e.g., trial home visit, just as LOA without any discharge or entry forms being required. On page 2-12 of the revised RAI Manual, CMS changed the LOA definition from Temporary home visit/therapeutic leave to Temporary **overnight** home visit/therapeutic leave. This and the definition of Discharge on page 2-10 lead me to the conclusion that any "LOA" that lasts more than 24 hours should be handled as a discharge. Is this correct?

ANSWER: The LOA definition has been revised by CMS. The following definition is included in the updated manual:

<u>Leave of Absence (LOA)</u>, which does not require completion of either a discharge assessment or an entry tracking record, occurs when a resident has a:

- ***Temporary home visit of at least one night; or***
- ***Therapeutic leave of at least one night; or***
- ***Hospital observation stay less than 24 hours and the hospital does not admit the patient.***

-Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable.

-Upon return, providers should make appropriate documentation in the medical record regarding any changes in the resident.

CMS is currently evaluating this topic for another clarification. AHFSA RAI PANEL – July, 2011
Updated by CMS, August 2011

4. **Discharge QUESTION**: If an admission is in the building for a couple of hours and then goes back out, does the facility have to do an entry and discharge? This was a new admission, not a readmission- who had such pain issues that the building had to send him back to the hospital…. He was not there over midnight
ANSWER: The person who has been admitted must have an Entry Record and a Discharge Assessment to track where and when they went after the hospital discharged them to the nursing home. Follow the instructions for Discharge Assessments on page 2- 34 to 2- 36 of the MDS 3.0 manual which says that if the person went to a hospital and was not there for 24 hours and did not get admitted they do not need to have a Discharge Assessment
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5. **Resident Transfer QUESTION**: We have a current event where nursing home A has a problem with flooding. They coordinated and sent their residents to nursing home B. Nursing home A wanted to know what they had to do. My instructions were for them was to transfer their residents via discharged return anticipated in order for the residents to be tracked. Is this correct? Also, there is a question whether the repairs to nursing home A can be done within 30 days. If the repairs take longer, say 31 or more days, is it correct to assume nursing home A will need to complete an admission assessments on the residents when they return or can our state have a policy that governs how facilities would handle transfers in the event of a natural disaster. On page 2-5 of the RAI Manual it states "When there has been a transfer of residents as a result of a natural disaster...the evacuating facility should contact their Regional Office, State Agency, and Medicare contractor for guidance." Please advise.
ANSWER: Your instruction to discharge the residents as “return anticipated” A0310 F- 11 was correct if the facility thought they would be returning within 30 days, however if the situation was that they could not see into the foreseeable future that the residents would be able to return to that facility, then a “return not anticipated” would have also been correct. If the residents do not return within 30 days they will have to have a new Admission Assessment completed. The information on page 2-5 of the manual directs a call to the State Survey Agency Office, the CMS Regional office and the Medicare FI contractor so that everyone will be informed of this situation. If the facility contacted you, then you need to speak to your superiors regarding this and ask who is to notify the CMS regional office. The facility can contact their Medicare FI office. The State Medicaid office will be informed via the submitted discharge assessments.
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Chapter 3 –

1. **Section K - QUESTION**:. The resident went to the hospital for urosepsis and dehydration and returned with **dehydration resolved**. This resident received I.V. fluids in the hospital during reference period and included in with Tobramyacin 15.5 ml = 620 mg with Dextrose 5% soln 100 ml piggyback. **Can this be coded in K0500A**? When I was reading the page K-9 it is stated that the IV fluids contained in IV piggybacks can be included on K500A. However the manual also stated that the IV fluids used to reconstitute and/or dilute medication for IV

administration and so on are not to be coded in K0500A and it should be coded in H0100H. Which one should be coded for the above scenario?
ANSWER: IV medications are only coded in Section O, O0100H and these were given in the hospital prior to admission to the nursing home, so they will be coded under Column 1 – While NOT a resident. Anything coded in Section K0500 must have supporting documentation to show the need for additional fluid intake, etc. and they can code the fluids given in the hospital for the dehydration. As said previously, the IV medication can be coded in Section O0100H – column 1 (not Section H as you stated).
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2. **M1200G QUESTION**: Can IV and Port dressings be coded under **M1200G**? I'm thinking so but wanted get the RAI panel perspective.
ANSWER: No, IV and Port dressings cannot be included in M1200G as they are not being used to treat a skin condition as specified by the MDS 3.0 manual on page M-34.
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3. **Section M QUESTION**: If a surgical wound is getting antibiotic ointment applied, you can code M1200f (surgical wound care). Can you also code **M1200H** (application of ointments/medications other than to feet)? My first reaction was 'no', but I don't see this item addressed specifically in the manual or the April PowerPoint. Both of these are RUG items, so the facility would be getting 2 qualifiers for the same service.
Section M ANSWER: The MDS 3.0 manual on page M-34 says that "Surgical Wound Care may include any intervention for treating or protecting any type of surgical wound. Examples my include topical dressing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application. The coding of M1200 H is only for the application of Ointments/Medications and yes it can be coded along with M1200F as the directions for M1200 say to code all that apply.
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4. **Section M QUESTION**: "The resident was re - admitted to the facility with five stage 4 pressure ulcers. At the time of the quarterly OBRA assessment, 4 of them had resolved. Therefore**, M0300 D**.1. was coded as "1" stage 4 ulcer, but M0300 D.2 was coded as "5" stage 4 ulcers that were present upon admission.
The provider is getting a notice that the value in M0300 D2 cannot be greater that the value in M0300 D1." The answer should be to code M0300 D1 as "1" (there was one stage 4 pressure ulcer upon return from the hospital); and to code M0300 D2 as "0" (number of Stage 4 pressure ulcers that were present upon admission/re-entry).
ANSWER: Here is how and why they need to correct the coding of this item. The question for D. Stage4 - M0300D1 is – Number of Stage 4 ulcers now: Their answer is 1 (which is what they have now). The question for M0300 D2 is – Number of **THESE (**our emphasis) Stage 4 ulcers that were present on admission/reentry – The answer will also be 1 (because the other 4 healed).
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5. **O0400 D QUESTION**: In regard to **Respiratory Therapy** and the coding of **O0400D**: **A.** Is a detailed initial evaluation required (such as that completed by a PT/OT/SLP) or is a narrative evaluation note acceptable? **B**. Is a pre- and post-treatment assessment required after the administration of a nebulizer treatment? **C.** May nebulizer treatment set-up minutes by a nurse that does not meet the qualified therapist criteria be counted on the MDS? **D**. Must a resident meet the skilled level of care criteria as defined in chapter 8 of the Medicare Benefit Policy Manual to qualify? **E**. Once a resident's respiratory treatment regimen is essentially stabilized (i.e., a stable resident with chronic nebulizer use), can treatment time be counted on the MDS?
ANSWER: **A.** The MDS 3.0 manual on page O-18 says that the services must be directly and specifically related to an '**active written treatment plan'** that is based on an initial evaluation performed by qualified personnel. **B**. According to the standards of practice for respiratory services, therapists shall assess all referred patients prior to the initiation of treatment, understand the objective of the procedure and document the patient's response to the therapy in the medical record and clarify with the physician if necessary. **C.** CMS has specified the services for a respiratory therapist and a respiratory nurse in the Appendix A Glossary (A-19) in the MDS 3.0 manual. Since each state's nurse practice act may be different, it is best to be sure that the respiratory nurse is qualified to perform respiratory services in your state**.** Only the minutes spent with the patient can count as therapy minutes – record only the actual minutes of therapy. The services do not qualify for hand-held medication dispensers. **D.** This question is best answered by your state's Medicare Fiscal Intermediary, Noridian**.** On page O-17 of the MDS 3.0 manual, it states that for purposes of the MDS, when the payer for therapy services is NOT Medicare Part B, follow the definitions and coding for Medicare Part A. **E.** Follow the MDS 3.0 manual on page O-18 for the criteria that must be met in order to record respiratory services.
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6. **Z0300 /HMOs /Vendor: QUESTION**
   We received this attachment from one of our clients. This is in regards to how they code a HMO assessment, they have been coding like PPS assessments to get the rugs, if they code as "99" they do not get a RUG score for the assessment and she said according to this document that they must now code as 99. She said that sometimes they must combine a PPS and HMO assessment together and that they must submit these kind of assessments. They feel this is a problem as when coding the HMO assess as 99 they do not get a RUG. We are using the DLL from CMS to produce the Medicare RUG score. How should we advise our client to get the Medicare RUG score?
   ANSWERS: **For the Vendor**: CMS is very specific that only MDS OBRA or Medicare PPS assessments will be allowed into the MDS QIES ASAP system. They have inserted Z0300 for the coding of HMO and/or Insurance RUG scores and to do that, the vendor needs to work with the facility. The facility may not combine any type of assessment with an HMO assessment. The HMO assessment has to be completed separately as it may not be transmitted to the ASAP QIES data base. If the HMO requires a RUG score for payment, then the facility can complete a PPS assessment, **but it cannot be submitted**.
   For the Facility: Work with the vendor to have a non RUG IV 66 grouper score in section Z0300 and then submit the assessment as an OBRA assessment. Work with the Case Manager of the HMO and educate them to the fact that you are not allowed to submit an assessment to the CMS QIES ASAP database that is not required and with MDS 3.0 you are not allowed to submit any assessment that is not an OBRA or PPS assessment which is only allowed for Medicare PPS of which the HMO is not a part.
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Chapter 4

Chapter 5

Chapter 6

1. **Chapter 6 QUESTION**: I received a call from a nursing home's MDS Coordinator who wanted to know if they could count changing a wound vac every other day as skill care. This is the only services they will be providing to a resident with the wound vac. How would I respond to this person? Is there anywhere I can go to find out what is considered skilled care?
   Chapter 6 ANSWER: You and the provider can find this information in the internet-only CMS Manual, at http://www.cms.gov/Manuals/IOM/list.asp .The manual they need to peruse is 100-02, Medicare Benefit Policy Manual, Chapter 8 – Coverage of SNF services. For Medicare SNF PPS, the assessent will first need to fall into a RUG that is Clinically Complex and above on the list of RUG-IV groups. They can find what is required for each RUG group in Chapter 6 of the MDS 3.0 manual, starting on page 6-25. As RAI Coordinators we cannot tell a provider whether something will or will not qualify for skilling or for a specific RUG group. When the assessment goes through the QIES ASAP they will be assigned a RUG score and will then know what RUG group that resident is in.
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OTHER:

1. **ASPEN ACO QUESTION**: Could I please get the directions for getting to the MDS 3.0 assessments in Aspen database system? Or where can I direct our state's surveyors to look and get MDS 3.0 assessment information? We are not seeing MDS 3.0 assessments in Aspen like we could for MDS 2.0.
ASPEN ACO ANSWER: Go into ASPEN and click on the facility to open; then scroll to the bottom of what is listed under the facility to the "Residents MDS 3.0" then right click on that and you will get the Residents MDS 3.0 Viewer. When you click to open the Residents MDS 3.0 Viewer, you will see all of the residents in that facility in alphabetical order. You then only have to click on a letter of the alphabet to bring up all residents whose last name starts with that letter. https://web.qiesnet.org/qiestosuccess/ this is the QIES website that also has access to the MDS viewer. If you can't access the ASPEN ACO, contact your State ASPEN Coordinator who will be listed in QTSO.
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